Suicide Assessment and Prevention in Early Psychosis

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Before we begin…

• People in on this webinar have lived experience
  – Know someone who died by suicide
  – Have experienced thoughts of suicide or have a suicide behavior history – or know someone who has.
  – Let’s have an **honest** conversation, but also be aware and respectful!

• **Language is powerful!**
  – NO: “committed suicide” or “killed themselves” → alludes to criminal or immoral view of suicide (e.g. “committed a crime” or “killed someone”)
    • Perceived as blaming and stigmatizing
  – YES: “died by suicide” or “suicide death”
    • Factual and similar to how we discuss other illnesses (e.g. “died from cancer”)

Outline for Today

• “Proactive” Suicide Risk Management
  • Initial and ongoing risk assessment (e.g. CSSRS, SBQ-R, ASQ)
  • Proactive interventions - Psychoeducation, Safety planning intervention (SPI)

• “Reactive” Suicide Risk Management
  • Crisis Management, including Safety Planning and increased monitoring
Suicide Risk in Mental Health

• In general, major mental illness is associated with elevated suicide risk
• For these disorders, rates vary between 8-15% for die by suicide
• Suicide is the 12\textsuperscript{th} leading cause of death in US
  – Every 3 years, there have been more deaths by suicide than all the deaths in the Vietnam war
• 2\textsuperscript{nd} leading cause of death among teens
• These are premature and preventable deaths
Suicide in Schizophrenia

- Of 42,773 deaths by suicide in 2014 - approximately 15% had psychosis (6416 people)
- Of individuals with schizophrenia, 20-40% attempt suicide, which is serious and can result in permanent damage or disability.
  - 50+% make repeated attempts
  - 4-10% die by suicide
- More likely in first year of illness, but risk is ongoing throughout illness
  - Rates are dropping due to early identification and intervention
Challenges of Suicide Assessment

• Risk is determined by a variety of factors: biological, psychological, familial, environmental, cultural…
  – Hard to determine which key factors you need to assess

• Risk is not always predictive of behavior
  – Many people have “thoughts” of suicide, but many never attempt

• While most people who make attempts or die by suicide have discussed their suicidal thoughts, most do not tell anyone right before they act.
Risk Assessment

• Excellent suicide prevention hinges on:
  – Comprehensive assessment of risk, in a proactive, structured and ongoing manner
  – Appropriate reaction to acute risk when it occurs
Key Points in Conducting a Risk Assessment

• Not based on any one risk factor (or set of risk factors)
• Risk and protective factors are assessed together to provide an overall picture
• Identifies factors that are modifiable with intervention
• Identifies and distinguishes between Acute/Proximal risk factors and warning signs from the ongoing, Chronic/Distal risk factors
• Guides treatment decisions
• In an ongoing care situation, risk assessment is not a single event; it must be evaluated over time → risk fluctuates
• Risk assessment supports, does not replace, clinician decision-making
Types of Risk Factors
Proximal vs. Distal vs. Warning Signs

• Distal (chronic, background) risk factors
  – Ongoing general characteristics or factors that are known to be associated with an elevated longer term risk for suicide; they exist in the individual’s background
  – Example: Suicide attempt 10 years ago, family history of suicide

• Proximal (acute) risk factors
  – Recent events or exacerbations of ongoing characteristics that can indicate imminent risk
  – Example: Suicide attempt within the last 3 months, major depressive episode

• Warning Signs (most acute risk factors)
  – Behaviors that are directly related to those that precede a spike in suicide risk in a particular individual, according to individual’s history; time frames varies from individual to individual from minutes to days
  – Example: Active, escalating suicidal ideation that is similar to the type of ideation present directly preceding a previous suicide attempt
Risk factors for suicidal ideation and behavior

**Distal/Background Variables**
- Demographics
- Aggression/Impulsivity
- Cognitive Inflexibility & Poor Decision making
- Head Injury
- Genetics – Stress sensitivity
- Low Serotonergic Function
- Premorbid Social Adjustment
- Family History of suicide
- Childhood Abuse/Trauma
- Early Loss
- Chronic Physical/Mental Illness
- Prior suicide attempts
- Chronic Substance Abuse
- Treatment difficulties

**Acute/Proximal Variables**
- Acute Psychiatric Episode (e.g., MDE, Psychosis)
- Acute Medical Illness
- Stressful Life Event
- Poor social support / Family conflict
- Acute Substance Use
- Access to Means

*Source: American Foundation for Suicide Prevention*
Warning Signs

**Behavior**
- Increased use of alcohol or drugs.
- Acting recklessly.
- Isolating and withdrawing from activities.
- Change in sleep, appetite, energy level.
- Visiting or calling people to say goodbye.
- Giving away prized possessions.
- Aggression or agitation.
- Discomfort due to psychosis.

**Things they Say:**
- Killing themselves.
- Having no reason to live.
- Being a burden to others.
- Feeling trapped.
- Unbearable pain.
- **Hopelessness**

**Mood:**
- Depression, despair.
- Loss of interest.
- Rage.
- Irritability.
- Humiliation.
- Anxiety.
Potential Protective Factors

• Have access to mental health treatment
• Positive attitude towards mental health treatment
• Feeling connected with others
• Effective problem solving skills
• Accepting and supportive social environment
• Reasons for living
• Limited access to lethal means
Other Considerations

• More males than females die by suicide
  – Females with psychosis at higher risk than general population
    OR other risk groups
• Single individuals (with psychosis) die by suicide more than those in relationships
  – Poor social functioning and lack of social support are risk factors
• Unemployment or lack of meaningful regular activities associated with higher risk
• Risk higher when individuals are 1) bothered by their psychosis or 2) have psychotic symptoms compelling them (ie. command hallucinations, thought insertion)
• Risk higher 3-6 mths post-hospitalization (esp. if not returning home)
• Depression is a risk factor → related to hopelessness
SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1. IDENTIFY RISK FACTORS
   Note those that can be modified to reduce risk

2. IDENTIFY PROTECTIVE FACTORS
   Note those that can be enhanced

3. CONDUCT SUICIDE INQUIRY
   Suicidal thoughts, plans, behavior, and intent

4. DETERMINE RISK LEVEL/INTERVENTION
   Determine risk. Choose appropriate intervention to address and reduce risk

5. DOCUMENT
   Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

www.sprc.org/library/safe_t_pcktcrd_edc.pdf
Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS
   - Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
   - Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity).
     Co-morbidity and recent onset of illness increase risk
   - Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations
   - Family history: of suicide, attempts or Axis I psychiatric disorders requiring hospitalization
   - Precipitants/Stressors/Interpersonal: triggering events leading to humiliation, shame or despair (e.g., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation.
   - Change in treatment: discharge from psychiatric hospital, provider or treatment change
   - Access to firearms

2. PROTECTIVE FACTORS  Protective factors, even if present, may not counteract significant acute risk
   - Internal: ability to cope with stress, religious beliefs, frustration tolerance
   - External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY  Specific questioning about thoughts, plans, behaviors, intent
   - Ideation: frequency, intensity, duration—in last 48 hours, past month and worst ever
   - Plan: timing, location, lethality, availability, preparatory acts
   - Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
   - Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live
   * For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors or disposition
   * Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.

4. RISK LEVEL/INTERVENTION
   - Assessment of risk level is based on clinical judgment, after completing steps 1-3
   - Reassess as patient or environmental circumstances change

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<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
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<tr>
<td>High</td>
<td>Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
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<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
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<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
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(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT  Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.)
SO HOW SHOULD WE ASSESS SUICIDE RISK?
Suicide Risk Assessment
The Problem…

• Lack of conceptual clarity about suicidal behavior → corresponds to lack of well-defined terminology

• Same behaviors are called a variety of things
  – E.g. threat, gesture

• Often negative and based on incorrect notions about seriousness and lethality of methods
  – E.g. manipulative, non-serious, passive
Consequences…

• Has negative implications on appropriate clinical management of suicidality and ability to study via research
  – If suicidal behavior and ideation cannot be properly identified, they cannot be properly understood, prevented or treated in any population or diagnosis
• Further, comparison across epidemiological or treatment/drug safety studies is limited, decreasing confidence in rates of suicide attempts
Example – Antidepressants & Teens

• Concerns about effects of antidepressant medication on suicide risk in children/adolescents
  – Meta-analyses found increased rates of “suicidality” across multiple clinical trials, BUT
    • Studies used different measures/criteria to evaluate “suicidality”
    • No individual trial (of any particular med) showed significant increase
      • NONE of these studies had a single individual die by suicide!

• Nevertheless, FDA placed “black box” warning (revised 2005): “Antidepressants increased the risk of suicidal thinking and behavior (“suicidality”) in short-term studies.”
  – Understood as strong dissuasion by clinicians → use with serious caution, monitor treated patients frequently
Examples

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<tr>
<th>Original Label</th>
<th>Text</th>
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<tbody>
<tr>
<td>Trauma</td>
<td>The Pt made an <strong>attempt to stab himself in the abdomen</strong> on day 49 which resulted in minor injury only. This was not considered a true suicide attempt and no action was taken.</td>
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<tr>
<td>Medication Error</td>
<td>The patient <strong>took 11 tablets impulsively</strong> and then went to school… the pt denied that it was a suicide attempt</td>
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<td>Hostility</td>
<td>Age 10: Before his mother’s call to the site and again after arguing with his stepfather, <strong>he wrapped a cord from the miniblinds around this neck, threatening to kill himself</strong></td>
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<tr>
<td>Suicide Attempt</td>
<td>Pt had thoughts of killing self but had no intention of acting on them</td>
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<tr>
<td>Suicide attempt</td>
<td>Hitting his head on the wall… The pt explained “It is like my thoughts are about to explode.”</td>
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** Severity goes both ways – some labels are MORE severe than they should be, while others are LESS severe than warranted **
C-SSRS

- Both research and clinical environments need a standard approach and systematic assessment
- FDA developed CSSRS to track suicidal events in multi-site NIMH trial of adolescents with history of suicidal attempts
  - Developed by leading experts/collaboration with Beck’s group
  - Use of C-SSRS classification algorithm led to a 50% reduction in suicide attempts (Posner et al., 2007) → Accurately identified those at true risk
- Considered the “Gold Standard” for assessing suicidal thought and behavior in adolescents and young adults, but can be used for all ages (Posner et al., 2011)
  - Includes items that research has shown are strongly associated with suicide risk
  - Required by FDA for all new trials
- Rating Periods
  - Baseline/Intake = Current (Past month) vs Lifetime
  - Follow up = Current (Past month) vs Since Last assessment
  - Use when SI/B reported during regular care OR at high risk period (post hospital)
Sources of Information

• Use any source of information that informs your clinical judgment and gets you the most clinically meaningful response

• Typically the client can provide best info about suicidal intent and thoughts, BUT also can be helpful to get collateral info (records, family, spouse, etc)
  – Client may refuse to talk about the event
Let’s look at the components of the C-SSRS…
Suicidal Ideation

1. Wish to die:
   “Have you wished you were dead or wished you could go to sleep and not wake up?”

2. Active thoughts of killing oneself:
   “Have you actually had thoughts of killing yourself?”

** If “NO” to both of these questions, you are finished with Suicidal Ideation section.**

** If “YES” to #1 OR #2, then continue with Suicidal Ideation and then Intensity of Ideation sections…**
## Suicidal Ideation

### BASELINE: Ask about LIFETIME and PAST MONTH

1. **Wish to be Dead** - Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

   *Have you (EVER/IN THE PAST MONTH) wished you were dead or wished you could go to sleep and not wake up? If yes, describe:*

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2. **Non-Specific Active Suicidal Thoughts** - General, non-specific thoughts of wanting to end one’s life/commit suicide (e.g. “I’ve thought about killing myself”) without thoughts of ways to kill oneself/associated methods, intent, or plan.

   *Have you (EVER/IN THE PAST MONTH) actually had any thoughts of killing yourself? If yes, describe:*

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**IF YES to CSSRS #1 OR #2, Continue in this section. IF NO TO BOTH, Go to Suicidal Behavior.**
Suicidal Ideation

3. Associated Thoughts of Methods:
   “Have you been thinking about how you might do this?”

4. Some Intent:
   “Have you had these thoughts AND some intention of acting on them?”

5. Plan and Intent:
   “Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?”

NOTE: Suicidal content of psychotic symptoms (ie. Command hallucinations to kill self or delusional beliefs of need to die) COUNT as ideation!
3. **Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act** - Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g. thought of method to kill self but not a specific plan). Includes person who would say, “I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it”.

_Have you (EVER/IN THE PAST MONTH) been thinking about how you might do this? If yes, describe:_

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4. **Active Suicidal Ideation with Some Intent to Act, without Specific Plan** – Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to “I have the thoughts but I definitely will not do anything about them”.

_Have you (EVER/IN THE PAST MONTH) had these thoughts and had some intention of acting on them? If yes, then describe:_

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5. **Active Suicidal Ideation with Specific Plan and Intent** - Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

_Have you (EVER/IN THE PAST MONTH) started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? If yes, describe:_

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**Intensity of Ideation – Rate for all levels of Ideation above**
Intensity of Ideation

• Once types of ideation are determined, ask a few follow up questions about most severe thought in specified timeframe:
  – Frequency
  – Duration
  – Controllability
  – Deterrents
  – Reasons for ideation: Stop the pain or make someone angry – stop the pain is worse

• All of these items are significantly predictive of death by suicide!
Clinical Monitoring Guidance

• For Intensity of Ideation, risk is greater when:
  – Thoughts are more frequent
  – Thoughts are of longer duration
  – Thoughts are less controllable
  – Have fewer deterrents to acting on thoughts
  – Stopping the pain is the reason

• Score of 4 (Some Intent) or 5 (Intent with Plan) → Indicates need for intervention
Suicidal Behavior

• **Definition of Suicide Attempt** = a self-injurious act committed with at least some intent to die as a result of the act
  – There does not have to be any injury or harm, just the potential for injury or harm (e.g. gun failing to fire, rope breaking)
  – Any “non-zero” intent to die – People often have mixed feelings. Does not have to be 100%, but has to be more than 0%
  – Intent to die and behavior must be linked → does not include non-suicidal self-injurious behavior
  – Intent can sometimes be inferred from the behavior or circumstances…
    • If they deny intent to die BUT they thought act could be lethal, intent can be inferred
    • “Clinically impressive” circumstances: highly lethal act where no other intent but suicide can be inferred (e.g. gunshot to head, jumping from bridge or high building, setting self on fire, taking 200 pills)
Suicidal Behavior

• A suicide attempt begins with the first act – the first pill ingested or scratch with the knife.
  – Even if they stop → aborted attempt
  – Are interrupted → interrupted attempt

• Questions to rate Actual Attempt:
  – Have you made a suicide attempt?
  – Have you done anything to harm yourself?
  – Have you done anything dangerous where you could have died?
  *Ask the extra questions here → client may not consider something a suicide attempt*
As Opposed to Non-suicidal Self-injurious Behavior

• Engaging in behavior PURELY (100%) for reasons other than to end one’s life:
  – Either to affect:
    • Internal state = feel better, relieve pain/distress.
      “Self-mutilation”
    AND/OR
    • External Circumstances = get sympathy, attention, make others angry, etc
  – BUT if even SMALL % of self wishes to die, then would be an attempt
Suicidal Behavior

• Important to ask the follow up “why?” questions in the Actual Attempt section!
  – Don’t just infer, ask them WHY they did it.
• Client may have multiple suicidal events that you need to assess
• May also have self-injurious behavior AND suicidal behavior
  • Need to ask “why” for each event → some may have intent (actual attempts) while other did not
**Actual Attempt:**

A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as a method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. **There does not have to be any injury or harm,** just the potential for injury or harm. If the person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g. gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

*Have you (EVER/IN THE PAST MONTH) made a suicide attempt?*

*Have you (EVER/IN THE PAST MONTH) done anything to harm yourself?*

*Have you (EVER/IN THE PAST MONTH) done anything dangerous where you could’ve died?*

**What did you do?**

*Did you ______ as a way to end your life?*

*Did you want to die (even a little) when you ______?*

*Were you trying to end your life when you ______?*

**Or did you think it was possible you could have died from ______?**

*Or did you do it purely for other reasons/without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?* (Self-injurious behavior without suicidal intent)

If yes, describe:

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**Yes □** | **No □** | **Yes □** | **No □** |

*Total # of Attempts* |

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**Has subject engaged in non-suicidal self-injurious behavior?**

*Yes □* | *No □* | *Yes □* | *No □* |

**Ensures that you assessed all possibilities and determined what is suicidal vs what isn’t**

May help you infer intent
C-SSRS Suicidal Behavior Levels

• **3 Types of Attempts:**
  – Actual Attempt
    • A self-injurious act committed with at least some intent to die
  
  – Interrupted Attempt:
    • Person starts to take steps to end their life BUT someone or something stops them → Hasn’t acted yet (actual attempt)

  – Aborted Attempt
    • Person starts to take steps to end their life BUT stops themselves before they have engaged in any self-destructive behavior (Has not started to act)

• **Preparatory Acts or Behavior**
  – Any other behavior (beyond saying something) with suicidal intent
Remember: Ideation & Behavior must be queried separately

- Just because they deny ideation, doesn’t mean that there won’t be suicidal behavior
- **You need to ask questions in Behavior section regardless of lack of ideation**
  - Clinician: “Have you wished you were dead or wished you could go to sleep and not wake up?”
  - Client: “Ummmm, no.”
  - Clinician: “Have you actually had any thoughts of killing yourself?”
  - Client: “No.”
  - Clinician: “Ok, but have you tried to harm yourself in order to end your life or because you wanted to die?”
  - Client: “I once impulsively tried to hang myself because I wanted to end it all, without even thinking about it.”
Suicide Behavior Questionnaire-Revised

- Ages 13-18
ASQ

- For ED, medical, outpatient/primary care settings
- Ages 10-21
Intervention

Collaboration with Yael Holoshitz, MD
Psychiatrist, OnTrackNY/WHCS

• The Risk Assessment guides clinical management and triage
• After suicide risk assessment, comes appropriate intervention...
  – “Proactive” management = No ACUTE risk → Consider the Safety Planning Intervention
  – “Reactive” management = ACUTE RISK → Consider alternative options to maintain safety (including SPI in some cases)
Proactive Risk Management

• Integrate suicide risk assessment as standard part of care
  – Intake evaluation
    • Screening → Risk assessment for positive screen
  – Reassessments at standard intervals (e.g. every 6 months)

• Integrate safety planning as part of standard relapse plan
  – Re-visit it regularly as part of treatment

• For individuals with elevated risk
  – Integrate other treatment options as part of care
Evidence-Based Risk Reduction Strategies

• Means Restriction
• Brief problem solving and coping skills (including distraction)
• Enhancing social support, identifying emergency contacts
• Motivational Enhancement for further treatment
Specialized Therapy for Suicide Prevention

- Collaborative Assessment and Management of Suicidality (CAMS)
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP)
- Often require specialized training: visit sprc.org, SAMHSA
What is the Safety Plan Intervention (SPI)?

• SPI is a clinical intervention that results in development of a one-page document to use when a suicidal crisis is emerging.

• Suicide risk fluctuates over time and SPI is a plan for managing and decreasing suicidal feelings and for staying safe when these feelings emerge
  – Remember, most attempts are IMPULSIVE!

• The individual at risk completes the SPI with the help of a clinician.

• Can be done in one brief session and refined over time.
Theoretical Foundation of SPI

• Problem solving capacity diminishes during crisis so over-practice with a specific template can help coping.
  – Creates a tool for participants to use in distress
  – Parallel to STOP-DROP-ROLL for fire safety.

• Clinician and suicidal individual collaborate to determine cognitive and behavioral strategies to use during suicidal crises
  – Step-wise increase in level of intervention: Starts “within self” and builds to seeking help in the psychiatric emergency room
  – HOWEVER individual can advance in steps without “completing” previous step…
Patient Safety Plan

Name: ___________________________ Date Completed: _______________________
Collateral/Family: ___________________ Clinician: _______________________

Step 1: Triggers & Stressors (behaviors, situations and circumstances that put you at emotional risk):
1. _____________________________
2. _____________________________
3. _____________________________

Step 2: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1. _____________________________
2. _____________________________
3. _____________________________

Step 3: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1. _____________________________
2. _____________________________
3. _____________________________

Step 4: People and social settings that provide distraction:
1. Name ___________________ Phone ___________________
2. Name ___________________ Phone ___________________
3. Place ___________________ 4. Place ___________________

Step 5: People whom I can ask for help:
1. Name ___________________ Phone ___________________
2. Name ___________________ Phone ___________________
3. Name ___________________ Phone ___________________

Step 6: Professionals or agencies I can contact during a crisis:
1. Clinician Name ___________________ Phone ___________________
Clinician Pager or Emergency Contact # ___________________
2. Clinician Name ___________________ Phone ___________________
Clinician Pager or Emergency Contact # ___________________
3. Suicide Prevention Lifeline Phone 1-800-273-TALK (8255) or call Sacramento County Line (916) 368-3111
4. Text “CONNECT” TO 7417415.
5. Call 911 or go to Local Emergency room: ___________________

Step 7: Making the environment safe:
1. _____________________________
2. _____________________________

The one thing that is most important to me and worth living for is:

______________________________

** Give copy to client, family members & put copy in chart **
The SPI is NOT:

- NOT a substitute for treatment
- NOT help for an individual in imminent danger of attempting suicide
- NOT a “no-suicide contract”
  – Avoid “no-suicide contracts”– all this does is ask clients to promise to stay alive without telling them HOW or giving them the resources to cope
SPI: When to use

- Consider using for “crisis prevention” in addition to suicide prevention; consider for all clients beginning treatment.
- For anyone with positive screen on C-SSRS.
- Annual or semi-annual revision.
- Whenever an event has occurred (hospitalization, suicide attempt, emergency room visit).
Other Interventions & Monitoring

What additional interventions can be incorporated into care when SPI isn’t enough?

• Skills training programs
• Family Involvement
• Medications
• Structured monitoring & follow up
Skills training programs

• Consider focusing on distress tolerance, interpersonal effectiveness, and problem-solving

• In one study, proximal non-suicidal self-injurious behavior was the strongest predictor of suicide behavior (Fedyszyn et al, 2012)

• Suicide attempts are often impulsive, accompanied by serious intent, and without help-seeking, suggesting they are carried out as a way to find relief from emotional distress
Family Involvement

• Young adults often live with their families
• Suicide attempts may frequently occur at home
• Information about risk detection, management, and information about who to contact should be provided early on in treatment, as the first few months of treatment are particularly high risk
  – Emergency contact name and an ROI should be obtained at intake
Family involvement

• If family notices change in behavior, this can be indication that risk is increasing
• If family reports: withdrawal, agitation, recent hopeless comments, make note and discuss with client
• During high risk times, family can work with team to help keep client safe and implement safety planning, crisis visits and phone calls, etc.
Medications

• Can be one component of suicide prevention
• Treat positive symptoms
• Clozapine and lithium have been shown to reduce suicidality; consider use if appropriate
• Consider giving smaller amounts of medication every visit to reduce lethal means
  – A recent study found that overdose was the most common method of suicide attempt in a FEP population (Fedyszyn et al, 2014)
  – Majority of suicides are very impulsive in nature. Smaller amounts of medicine = reduction of lethal means
Structured Follow-up & Monitoring

- Standard clinical training does not provide a framework for increasing contact, which is sometimes necessary when people are at elevated risk
- During crisis, consider increased frequency of visits or contact (home, clinic) in addition to check-in calls/texts
3-Step Process

• **Mood check & Risk assessment**
  – May require crisis intervention if imminent risk

• **Review and Update Safety Plan**
  – Are they using it? Also always check about access to lethal means

• **Facilitate & Enhance Treatment Engagement**
  – Problem solve around obstacles to treatment engagement
Coordination with the Team

• Proactive management works best if the Care Team is informed and involved.
• Clearly communicate the know risk factors, components of the safety plan and any other interventions
• Ensure rapid communication between team members to monitor changes in risk
“Reactive” Risk Management

• Individual is at ACUTE RISK based on:
  – Risk Assessment = increased ideation, intent, behaviors
  – Increased psychosis symptoms
  – Unable to engage in safety skills
  – Lack of family/collateral support
  – Not able/willing to engage in treatment

• Hospitalization or crisis treatment is necessary
  – Know the hospitalization protocol in your clinic!
SAMHSA funded training resources

• Suicide Prevention Resource Center, www.sprc.org  Assessing and Managing Suicide Risk (AMSR)

• SAFE-T Card and SuicideSafe app walks clinicians through a suicide risk assessment

• Treatment Improvement Protocol 50-Suicide and Substance Abuse

• For FEP: http://www.nasmhpd.org/content/part-i-recognizing-suicidal-ideation-and-behavior-individuals-first-episode-psychosis
Link to SPI Training


- Safety Plan Template: [www.suicidesafetyplan.com](http://www.suicidesafetyplan.com)
National Suicide Prevention Lifeline

• Joint Commission recommends giving those with suicidal ideation the Lifeline number - 1-800-273-TALK (8255)
  – Link to Veterans Crisis Line
• 160+ local crisis centers
  – WellSpace Health
• Local Lifeline crisis centers
  – The Effort: (916) 368-3111
References

• Pompili et al. Suicide risk in schizophrenia: learning from the past to change the future. Annals of General Psychiatry 2007, 6:10.
• Geoffroy MC, Turecki G. The developmental course of suicidal ideation in first-episode psychosis. Lancet Psychiatry 2016.
Questions?